Coronavirus Symptom Disclosure Form

Full Name

Date

Have you experienced any of the following symptoms in the past 14 days?

☐ Fever or chills ☐ Cough ☐ Shortness of breath or difficulty breathing ☐ Fatigue ☐ Muscle or body aches ☐ Headache ☐ Loss of taste or smell ☐ Sore throat ☐ Congestion or runny nose ☐ Nausea or vomiting ☐ Diarrhea

In the past 14 days, have you been in close contact with anyone who has tested positive for COVID-19?

☐ Yes ☐ No

In the past 14 days, have you tested positive for COVID-19?

☐ Yes ☐ No

Additional Comments (optional):

Signature

Date